		FOR OHF USE					

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

I. IDPH Facility ID Number: 0030551

Facility Name: Brightview Care Center

Address: 4538 N. Beacon (Number) Chicago (City) 60640 (Zip Code)

County: Cook

Telephone Number: (773) 275-7200 **Fax #** (773) 275-7543

IDPA ID Number: 363408520001

Date of Initial License for Current Owners: 02/01/86

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Cary N. Drazner, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	143	Skilled (SNF)	143	52,338	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	143	TOTALS	143	52,338	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	28,059	938	2,149	31,146	8
9	SNF/PED					9
10	ICF	14,742	278	74	15,094	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,801	1,216	2,223	46,240	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.35%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/1/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 1,890

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	204,334	40,878	10,065	255,277		255,277		255,277			1
2	Food Purchase		254,775		254,775	(16,272)	238,503	(67)	238,436			2
3	Housekeeping	229,094	50,502		279,596		279,596	750	280,346			3
4	Laundry	85,617	14,080		99,697		99,697		99,697			4
5	Heat and Other Utilities			140,783	140,783		140,783	2,712	143,495			5
6	Maintenance	47,074	22,777	69,618	139,469		139,469	(6,400)	133,069			6
7	Other (specify):*							21	21			7
8	**TOTAL General Services**	566,119	383,012	220,466	1,169,597	(16,272)	1,153,325	(2,984)	1,150,341			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,603,760	104,653	157,427	1,865,840		1,865,840	(34)	1,865,806			10
10a	Therapy	63,521	3,171	5,804	72,496		72,496		72,496			10a
11	Activities	84,746	5,697	2,119	92,562		92,562		92,562			11
12	Social Services	136,513			136,513		136,513		136,513			12
13	Nurse Aide Training											13
14	Program Transportation			93	93		93		93			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,888,540	113,521	174,443	2,176,504		2,176,504	(34)	2,176,470			16
	C. General Administration											
17	Administrative	206,208		72,000	278,208		278,208	(14,092)	264,116			17
18	Directors Fees											18
19	Professional Services			275,563	275,563		275,563	(202,240)	73,323			19
20	Dues, Fees, Subscriptions & Promotions			49,731	49,731		49,731	(32,097)	17,634			20
21	Clerical & General Office Expenses	123,442	29,735	60,248	213,425		213,425	49,080	262,505			21
22	Employee Benefits & Payroll Taxes			408,438	408,438	16,272	424,710		424,710			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,823	2,823		2,823	637	3,460			24
25	Other Admin. Staff Transportation			1,085	1,085		1,085	76	1,161			25
26	Insurance-Prop.Liab.Malpractice			172,168	172,168		172,168	944	173,112			26
27	Other (specify):*							35,416	35,416			27
28	**TOTAL General Administration**	329,650	29,735	1,042,056	1,401,441	16,272	1,417,713	(162,276)	1,255,437			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,784,309	526,268	1,436,965	4,747,542		4,747,542	(165,294)	4,582,248			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Brightview Care Center #0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			48,468	48,468		48,468	114,918	163,386			30
31	Amortization of Pre-Op. & Org.							5,920	5,920			31
32	Interest			24,268	24,268		24,268	118,772	143,040			32
33	Real Estate Taxes							206,966	206,966			33
34	Rent-Facility & Grounds			480,974	480,974		480,974	(480,974)				34
35	Rent-Equipment & Vehicles							152	152			35
36	Other (specify):*											36
37	**TOTAL Ownership**			553,710	553,710		553,710	(34,246)	519,464			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		137,093	84,938	222,031		222,031		222,031			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,508	78,508		78,508		78,508			42
43	Other (specify):*	73,746			73,746		73,746	(73,746)				43
44	**TOTAL Special Cost Centers**	73,746	137,093	163,446	374,285		374,285	(73,746)	300,539			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,858,055	663,361	2,154,121	5,675,537		5,675,537	(273,286)	5,402,251			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(109,262)	30		9
10	Interest and Other Investment Income	(561)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(67)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(11,891)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(38,120)	21		24
25	Fund Raising, Advertising and Promotional	(18,193)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(112,618)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (290,712)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	17,426		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 17,426		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (273,286)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Brightview Care Center

ID# 0030551

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty Income	$ (34)	10	1
2	Marketing Salaries	(73,746)	43	2
3	Franchise Tax	(568)	21	3
4	Theft & Loss	(324)	21	4
5	COPE Dues	(2,595)	20	5
6	Building Co. - Annual Fee	(350)	20	6
7	Building Co. - Professional Fees	(2,900)	19	7
8	Prior Year Legal Fees	(424)	19	8
9	Capitalized R&M	(13,110)	6	9
10	Excess Salaries	(18,567)	17	10
11				11
12				12
13				13
14				14
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16				16
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97				**97**
98				**98**
99				**99**
100				**100**
101	Total	**(112,618)**		**101**

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(67)											(67)	2
3	Housekeeping			750									750	3
4	Laundry													4
5	Heat and Other Utilities			1,208	1,504								2,712	5
6	Maintenance	(13,110)		5,529	1,181								(6,400)	6
7	Other (specify):*				21								21	7
8	**TOTAL General Services**	(13,177)		7,487	2,706								(2,984)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(34)											(34)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(34)											(34)	16
	C. General Administration													
17	Administrative	(18,567)		57,788	571	(53,884)							(14,092)	17
18	Directors Fees													18
19	Professional Services	(3,324)	2,900	(202,301)	124	361							(202,240)	19
20	Fees, Subscriptions & Promotions	(33,029)	350	522	7	53							(32,097)	20
21	Clerical & General Office Expenses	(39,012)	(160)	87,929	216	107							49,080	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			637									637	24
25	Other Admin. Staff Transportation			76									76	25
26	Insurance-Prop.Liab.Malpractice			793	151								944	26
27	Other (specify):*			34,000		1,416							35,416	27
28	**TOTAL General Administration**	(93,932)	3,090	(20,556)	1,069	(51,947)							(162,276)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(107,143)	3,090	(13,069)	3,775	(51,947)							(165,294)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(109,262)	213,560	9,405	1,101	114							114,918	30
31	Amortization of Pre-Op. & Org.		5,920										5,920	31
32	Interest	(561)	116,379	454	2,500								118,772	32
33	Real Estate Taxes		204,974		1,992								206,966	33
34	Rent-Facility & Grounds		(480,974)	10,937	(10,937)								(480,974)	34
35	Rent-Equipment & Vehicles			152									152	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(109,823)	59,859	20,948	(5,344)	114							(34,246)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(73,746)											(73,746)	43
44	**TOTAL Special Cost Centers**	(73,746)											(73,746)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(290,712)	62,949	7,879	(1,569)	(51,833)							(273,286)	45

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Brightview Building Company		Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 480,974	Brightview Building Company	100.00%	$	$ (480,974)	1
2	V	32	Interest Income / Expense	58,215	Brightview Building Company	100.00%	174,594	116,379	2
3	V	30	Depreciation		Brightview Building Company	100.00%	213,560	213,560	3
4	V	31	Amortization		Brightview Building Company	100.00%	5,920	5,920	4
5	V	33	Real Estate Tax		Brightview Building Company	100.00%	204,974	204,974	5
6	V	20	Annual Fee		Brightview Building Company	100.00%	350	350	6
7	V	19	Legal		Brightview Building Company	100.00%	2,900	2,900	7
8	V	21	Misc. Income	160	Brightview Building Company	100.00%		(160)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 539,349			$ 602,298	$ * 62,949	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MANAGCARE, INC.	100.00%	$ 750	$ 750	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,208	1,208	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	5,529	5,529	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%			18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	57,788	57,788	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	187	187	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	522	522	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	87,929	87,929	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	637	637	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	76	76	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	793	793	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	34,000	34,000	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	9,405	9,405	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	454	454	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	10,937	10,937	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	152	152	30
31	V	19	HOME OFFICE	202,488	MANAGCARE, INC.	100.00%		(202,488)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 202,488			$ 210,367	$ * 7,879	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MAZEL MANAGEMENT	100.00%	$ 1,504	$ 1,504	15
16	V	6	REPAIRS & MAINT.		MAZEL MANAGEMENT		1,181	1,181	16
17	V	7	EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT		21	21	17
18	V	17	ADMIN.-M. WOLF		MAZEL MANAGEMENT		571	571	18
19	V	19	PROFESSIONAL FEES		MAZEL MANAGEMENT		124	124	19
20	V	20	FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		7	7	20
21	V	21	CLERICAL & GENERAL		MAZEL MANAGEMENT		216	216	21
22	V	26	INSURANCE		MAZEL MANAGEMENT		151	151	22
23	V	30	DEPRECIATION		MAZEL MANAGEMENT		1,101	1,101	23
24	V	32	INTEREST EXPENSE		MAZEL MANAGEMENT		2,500	2,500	24
25	V	33	REAL ESTATE TAXES		MAZEL MANAGEMENT		1,992	1,992	25
26	V	34	RENT	10,937	MAZEL MANAGEMENT			(10,937)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 10,937			$ 9,368	$ * (1,569)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 18,116	$ 18,116	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	361	361	16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	53	53	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	107	107	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	1,416	1,416	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	114	114	20
21	V								21
22	V	17	MANAGEMENT FEES	72,000	INTERCARE, LTD. C/O MANAGCARE	100.00%		(72,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 72,000			$ 20,167	$ * (51,833)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Yosef Davis	Owner	Administrative	72.34%	See Attached	12.37	20.62%	salary, alloc.	$ 33,116	17-1,17-7	1
2	Moshe Davis	Dir of Operations	Administrative		See Attached	10.00	16.67%	salary	25,130	17-1	2
3	Yehoshua Davis	Adminstrator	Administrative		See Attached	21.00	35.00%	salary	54,870	17-1	3
4	Chasida Davis	Relative	Clerical		See Attached	8.53	21.33%	allocation	8,205	21-7	4
5	Shoshana Braun	Relative	Clinical Support		See Attached	12.50	31.25%	salary	9,519	10-1	5
6	Moshe Wolf	Relative	Administrative		See Attached	11.94	21.32%	allocation	15,366	17-7	6
7	Stanley Klem	Owner	Administrative	2.13%	See Attached	9.38	21.32%	allocation	24,384	17-7	7
8	Renee Wolf	Relative	Clerical		See Attached	8.53	21.32%	allocation	3,983	21-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 174,573		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MANAGCARE, INC.
Street Address: 3553 W. PETERSON AVE -3RD FLR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PATIENT DAYS	216,882	5	$ 3,519	$	46,240	$ 750	1
2	5	UTILITIES	PATIENT DAYS	216,882	5	5,668		46,240	1,208	2
3	6	REPAIRS AND MAINT.	PATIENT DAYS	216,882	5	25,935		46,240	5,529	3
4	10	NURSING SALARIES	PATIENT DAYS	216,882	5			46,240		4
5	17	ADMINISTRATIVE	PATIENT DAYS	216,882	5	271,046	271,046	46,240	57,788	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	216,882	5	875		46,240	187	6
7	20	FEES, SUBSCRIPTIONS	PATIENT DAYS	216,882	5	2,447		46,240	522	7
8	21	CLERICAL AND GENERAL	PATIENT DAYS	216,882	5	412,419	353,888	46,240	87,929	8
9	24	SEMINARS	PATIENT DAYS	216,882	5	2,990		46,240	637	9
10	25	ADMIN. STAFF TRANS.	PATIENT DAYS	216,882	5	357		46,240	76	10
11	26	INSURANCE	PATIENT DAYS	216,882	5	3,719		46,240	793	11
12	27	GEN. ADMIN. EMP. BEN.	PATIENT DAYS	216,882	5	159,470		46,240	34,000	12
13	30	DEPRECIATION	PATIENT DAYS	216,882	5	44,112		46,240	9,405	13
14	32	INTEREST EXPENSE	PATIENT DAYS	216,882	5	2,130		46,240	454	14
15	34	RENT - BUILDING (RELATED)	PATIENT DAYS	216,882	5	51,300		46,240	10,937	15
16	35	EQUIPMENT RENTAL	PATIENT DAYS	216,882	5	711		46,240	152	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 986,698	$ 624,934		$ 210,367	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAZEL MANAGEMENT
Street Address: 3553 W.PETERSON AVE.
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. PATIENT DAYS	216,882	5	$ 7,053	$	46,240	$ 1,504	1
2	6	REPAIRS & MAINT.	MNGCR. PATIENT DAYS	216,882	5	5,541		46,240	1,181	2
3	7	EMPLOYEE BEN.-R&M SAL.	MNGCR. PATIENT DAYS	216,882	5	96		46,240	21	3
4	17	ADMIN.-M. WOLF	MNGCR. PATIENT DAYS	216,882	5	2,679		46,240	571	4
5	19	PROFESSIONAL FEES	MNGCR. PATIENT DAYS	216,882	5	580		46,240	124	5
6	20	FEES, SUBSCRIPTIONS	MNGCR. PATIENT DAYS	216,882	5	31		46,240	7	6
7	21	CLERICAL & GENERAL	MNGCR. PATIENT DAYS	216,882	5	1,012		46,240	216	7
8	26	INSURANCE	MNGCR. PATIENT DAYS	216,882	5	706		46,240	151	8
9	30	DEPRECIATION	MNGCR. PATIENT DAYS	216,882	5	5,162		46,240	1,101	9
10	32	INTEREST EXPENSE	MNGCR. PATIENT DAYS	216,882	5	11,726		46,240	2,500	10
11	33	REAL ESTATE TAXES	MNGCR. PATIENT DAYS	216,882	5	9,342		46,240	1,992	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 43,928	$		$ 9,368	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: INTERCARE, LTD. C/O MANAGCARE
Street Address: 3553 W. PETERSON AVE. 3RD FLOOR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	60	7	$ 87,900	$ 87,900	12	$ 18,116	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	60	7	1,750		12	361	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	60	7	257		12	53	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	60	7	521		12	107	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	60	7	6,869		12	1,416	5
6	30	DEPRECIATION	AVG. HOURS WORKED	60	7	552		12	114	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 97,849	$ 87,900		$ 20,167	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	MB Financial		X	Mortgage			$ 4,000,000	$ 3,721,441	2/1/07	Prime	$ 174,594	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	MB Financial		X	Line of Credit				60,000	8/5/05	5.2500	1,201	6
7	Brightview Building Co.	X		Working Capital							23,067	7
8	See Supplemental Schedule										2,954	8
9	TOTAL Facility Related						$ 4,000,000	$ 3,781,441			$ 201,816	9
	B. Non-Facility Related*											
10	Interest Income										(561)	10
11	Interest Income (Bldg Co)										(58,215)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (58,776)	14
15	TOTALS (line 9+line14)						$ 4,000,000	$ 3,781,441			$ 143,040	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocation ManagCare		X				$	$			$ 454	8
9	Allocation Mazel Mgmt		X								2,500	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										2,954	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 144,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 173,966	2
3. Under or (over) accrual (line 2 minus line 1).		$ 29,966	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 177,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 206,966	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	146,143	8
	2000	136,212	9
	2001	139,755	10
	2002	141,322	11
	2003	171,974	12

2004 Accrual = 2003 Expense $171,974 x 1.03 = $177,000 (rounded)

RE Tax allocated from Mazel Management $1,992

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brightview Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-115-017-0000	Long Term Care Property	$ 68,791.35	$ 68,791.35
2.	14-17-115-018-0000	Long Term Care Property	$ 67,113.75	$ 67,113.75
3.	14-17-115-030-0000	Long Term Care Property	$ 36,068.80	$ 36,068.80
4.	See Attached	Allocated - Mazel Management	$ 40,849.28	$ 1,996.70
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 212,823.18	$ 173,970.60

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brightview Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0030551

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 29,600
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 5,920
4. Dates Incurred: 1/27/02

Nature of Costs: Costs of Refinance
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 73,992	1
2					2
3	TOTALS			$ 73,992	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1986	10,306		20	543	543	10,109	9
10	Various			1987	4,719		20	236	236	4,132	10
11	Various			1988	2,895		20	145	145	2,439	11
12	Various			1989	67,265		20	3,272	(3,272)	52,864	12
13	Various			1991	22,384		20	1,120	1,120	13,120	13
14	Various			1992	17,019		20	143	143	14,324	14
15	Various			1993	44,200		20	2,211	2,211	25,288	15
16	Various			1994	63,594		20	3,181	3,181	33,476	16
17	Various			1995	7,105		20	356	356	3,408	17
18	Various			1996	37,640		20	1,882	1,882	16,567	18
19	Various			1997	17,411		20	871	871	6,168	19
20	Various			1998	49,850		20	2,497	2,497	15,850	20
21	Various			1999	215,484		20	10,777	10,777	59,937	21
22	Various			2000	47,834		20	2,392	2,392	10,722	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		2,433,968	213,560		80,998	(132,562)	1,729,657	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		56,600	2,553		2,445	(108)	42,615	68
69	Financial Statement Depreciation			15,681			(15,681)		69
70	TOTAL (lines 4 thru 69)		$ 3,098,274	$ 231,794		$ 113,069	$ (125,269)	$ 2,040,676	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,098,274	$ 231,794		$ 113,069	$ (118,725)	$ 2,040,676	1
2	Alarms	2001	10,314		20	516	516	1,848	2
3	Electrical Work	2001	2,740		20	137	137	491	3
4	Rewire Patio	2001	2,575		20	129	129	461	4
5	Door Detectors	2001	3,600		20	360	360	1,440	5
6	Elevator Valve	2001	2,900		20	290	290	967	6
7	Motor Panel	2001	1,800		20	180	180	570	7
8	Circuit & Outlet	2001	1,195		20	60	60	184	8
9	Cctv Monitor	2001	1,206		20	60	60	191	9
10	Cctv Basemt Monitor	2001	1,037		20	52	52	160	10
11	Door Edge Protectors	2001	2,318		20	116	116	454	11
12	Wall Heater	2001	696		20	35	35	107	12
13	A/C Repair	2001	1,185		20	59	59	217	13
14	Motor	2001	847		20	42	42	141	14
15	Elevator Parts	2001	1,721		20	86	86	315	15
16	Elevator Repairs	2001	900		20	45	45	158	16
17	Duct Install,Fire Damper	2002	1,975		20	198	198	510	17
18	Boiler Ignitor Safety Control	2002	1,125		20	113	113	328	18
19	Install New Detector Edge In Elevator	2002	2,100		20	105	105	280	19
20	Conrtol Panels	2002	5,525		20	553	553	1,243	20
21	Elevator Door Detector System	2002	2,679		20	134	134	301	21
22	Hot Water Heater Coil	2002	1,422		20	119	119	247	22
23	Security Camera For Pkg Lot	2002	1,087		20	155	155	324	23
24	Security Camera For Rear Door	2002	744		20	106	106	221	24
25	Call Pad	2002	1,099		20	110	110	247	25
26	Concrete Steps	2002	2,620		20	262	262	677	26
27	Ejector Pump	2002	1,078		20	108	108	314	27
28	Hallway P.A.System	2002	3,774		20	377	377	1,132	28
29	Elevator	2002	5,862		20	293	293	782	29
30	Smoke Detector/Ceiling	2002	1,409		20	141	141	305	30
31	Tiles	2002	1,035		20	104	104	250	31
32	Delivery Security Camera	2003	1,858		20	93	93	139	32
33	Front Door Security Camera	2003	1,858		20	93	93	147	33
34	TOTAL (lines 1 thru 33)		$ 3,170,558	$ 231,794		$ 118,300	$ (113,494)	$ 2,055,827	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,170,558	$ 231,794		$ 118,300	$ (113,494)	$ 2,055,827	1
2	Condensing Unit	2003	7,825		20	652	652	924	2
3	A/C Compressor Circuit	2003	1,370		20	114	114	162	3
4	Piston Packing & Installation	2003	600		20	30	30	38	4
5	Thermostat & Actuator Control	2003	1,037		20	52	52	104	5
6	Connect Air Handler To Fire Alarm	2003	781		20	39	39	62	6
7	Service On Pa System & Monitor System	2003	738		20	37	37	55	7
8	Repair Cooling Coil & Air Handler	2003	3,992		20	200	200	366	8
9	Freezer Stat Controls	2003	940		20	47	47	86	9
10	Faucets *	2004	5,750		20	335	335	335	10
11	Door Hardware *	2004	2,429		20	142	142	142	11
12	Door Hardware *	2004	1,147		20	57	57	57	12
13	Waiting Room	2004	30,517		20	1,526	1,526	1,526	13
14	Water Heater *	2004	3,785		20	53	53	53	14
15	Door Detector *	2004	1,892		20	55	55	55	15
16	Valve Tamper Panel *	2004	5,693		20	190	190	190	16
17	Pump Moter *	2004	3,137		20	13	13	13	17
18	Elevator Repair	2004	2,500		20	94	94	94	18
19	Monitor System Repair	2004	852		20	36	36	36	19
20	Monitor System Repair	2004	706		20	29	29	29	20
21	Kitchen Air Handler *	2004	804		20	30	30	30	21
22	Chiller Repair *	2004	668		20	14	14	14	22
23	Electrical Work *	2004	2,731		20	34	34	34	23
24	Fire Alarm Repair *	2004	596		20	2	2	2	24
25	Kitchen Doors	2004	775		20	39	39	39	25
26	Paint	2004	634		20	24	24	24	26
27	Locks *	2004	1,586		20	40	40	40	27
28	Door Locks	2004	837		20	42	42	42	28
29	Door Locks	2004	419		20	21	21	21	29
30	* Added After 6/30/04 Capital Report	2004			20				30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,255,300	$ 231,794		$ 122,247	$ (109,547)	$ 2,060,400	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,255,300	$ 231,794		$ 122,247	$ (109,547)	$ 2,060,400	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,255,300	$ 231,794		$ 122,247	$ (109,547)	$ 2,060,400	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,255,300	$ 231,794		$ 122,247	$ (109,547)	$ 2,060,400	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,255,300	$ 231,794		$ 122,247	$ (109,547)	$ 2,060,400	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,255,300	$ 231,794		$ 122,247	$ (109,547)	$ 2,060,400	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,255,300	$ 231,794		$ 122,247	$ (109,547)	$ 2,060,400	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,255,300	$ 231,794		$ 122,247	$ (109,547)	$ 2,060,400	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,255,300	$ 231,794		$ 122,247	$ (109,547)	$ 2,060,400	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,255,300	$ 231,794		$ 122,247	$ (109,547)	$ 2,060,400	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,255,300	$ 231,794		$ 122,247	$ (109,547)	$ 2,060,400	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,255,300	$ 231,794		$ 122,247	$ (109,547)	$ 2,060,400	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,255,300	$ 231,794		$ 122,247	$ (109,547)	$ 2,060,400	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,255,300	$ 231,794		$ 122,247	$ (109,547)	$ 2,060,400	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,255,300	$ 231,794		$ 122,247	$ (109,547)	$ 2,060,400	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 3,255,300	$ 231,794		$ 122,247	$ (109,547)	$ 2,060,400	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,255,300	$ 231,794		$ 122,247	$ (109,547)	$ 2,060,400	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	143		1988	1968	$ 1,899,326	$ 106,632	35	$ 54,266	$ (52,366)	$ 1,702,925	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Interior Remodeling			2004	534,642	106,928	20	26,732	(80,196)	26,732	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,433,968	$ 213,560		$ 80,998	$ (132,562)	$ 1,729,657	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Mazel Mgmt		1985		$ 21,996	$ 884	30	$ 733	$ (151)	$ 14,114	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - ManagCare			1997	2,564	114	20	256	142	1,902	9
10	Allocation - ManagCare			1993	201		20	10	10	116	10
11	Allocation - ManagCare			1988	314	10	20	15	5	254	11
12	Allocation - ManagCare			1986	23,788	1,215	20	1,089	126	21,975	12
13											13
14	Allocation - Mazel Management			2001	462	12	20	23	11	81	14
15	Allocation - Mazel Management			2000	233	6	20	12	6	50	15
16	Allocation - Mazel Management			1998	823	28	20	41	13	276	16
17	Allocation - Mazel Management			1997	767	20	20	38	18	281	17
18	Allocation - Mazel Management			1996	523	6	20	26	20	224	18
19	Allocation - Mazel Management			1995	118	3	20	6	3	57	19
20	Allocation - Mazel Management			1994	467	9	20	23	14	221	20
21	Allocation - Mazel Management			1993	276	8	20	14	6	158	21
22	Allocation - Mazel Management			1991	207	7	20	10	3	131	22
23	Allocation - Mazel Management			1990	321	7	20	16	9	231	23
24	Allocation - Mazel Management			1989	201	5	20	9	4	131	24
25	Allocation - Mazel Management			1987	457	9	15		(9)	457	25
26	Allocation - Mazel Management			1986	1,844	96	20	78	(18)	1,720	26
27	Allocation - Mazel Management			1985	128		10			128	27
28											28
29	Allocation - Inter Care Ltd.			2001	910	114	20	46	(68)	108	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 56,600	$ 2,553		$ 2,445	$ 144	$ 42,615	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 307,220	$ 20,544	$ 33,840	$ 13,296	10	$ 189,663	71
72	Current Year Purchases	3,867	13,345	306	(13,039)	10	306	72
73	Fully Depreciated Assets	125,657				10	125,610	73
74								74
75	TOTALS	$ 436,744	$ 33,889	$ 34,146	$ 257		$ 315,579	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocation - ManagCare		2002	$ 42,517	$ 6,966	$ 6,994	$ 28	5	$ 12,258	76
77										77
78										78
79										79
80	TOTALS			$ 42,517	$ 6,966	$ 6,994	$ 28		$ 12,258	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	3,808,553	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	272,649	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	163,387	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(109,262)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	2,388,237	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 35,149	92
93			93
94			94
95		$ 35,149	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 152 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 34,155	$		$ 34,155	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			17,721			17,721	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			33,026			33,026	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				70,862		70,862	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					25,730		25,730	12
13	Other (specify): See Supplemental					36	40,501		40,537	13
14	TOTAL			$		$ 84,938	$ 137,093		$ 222,031	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 205,656	$ 280,002	1
2	Cash-Patient Deposits	3,000	3,000	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	418,025	472,714	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	182,332	182,332	6
7	Other Prepaid Expenses	3,355	3,355	7
8	Accounts Receivable (owners or related parties)	164,181	783,365	8
9	Other(specify): See Attached Schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 976,549	$ 1,724,768	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		2,560,642	14
15	Leasehold Improvements, at Historical Cost	579,560	579,560	15
16	Equipment, at Historical Cost	437,371	517,371	16
17	Accumulated Depreciation (book methods)	(565,858)	(2,769,907)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	35,149	47,482	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 486,222	$ 1,085,148	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,462,771	$ 2,809,916	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 526,646	$ 526,645	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	49,381	49,381	28
29	Short-Term Notes Payable	60,000	60,000	29
30	Accrued Salaries Payable	135,358	135,358	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,283	11,283	31
32	Accrued Real Estate Taxes(Sch.IX-B)		177,000	32
33	Accrued Interest Payable	24,793	42,678	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	845,845	191,611	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,653,306	$ 1,193,956	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,721,441	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,721,441	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,653,306	$ 4,915,397	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (190,535)	$ (2,105,481)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,462,771	$ 2,809,916	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 201,576	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 201,576	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(392,111)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (392,111)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (190,535)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,215,337	1
2	Discounts and Allowances for all Levels	(216,642)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,998,695	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	164,406	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 164,406	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	67,799	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,981	19
20	Radiology and X-Ray	1,170	20
21	Other Medical Services	43,415	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 118,365	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	561	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 561	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,399	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,399	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,283,426	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,169,597	31
32	Health Care	2,176,504	32
33	General Administration	1,401,441	33
	B. Capital Expense		
34	Ownership	553,710	34
	C. Ancillary Expense		
35	Special Cost Centers	295,777	35
36	Provider Participation Fee	78,508	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,675,537	40
41	**Income before Income Taxes (line 30 minus line 40)****	(392,111)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (392,111)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** not complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,832	2,080	$ 67,814	$ 32.60	1
2	Assistant Director of Nursing	806	922	22,104	23.97	2
3	Registered Nurses	13,354	13,959	360,490	25.82	3
4	Licensed Practical Nurses	23,463	24,866	500,648	20.13	4
5	Nurse Aides & Orderlies	64,413	68,842	630,305	9.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,019	6,513	63,521	9.75	8
9	Activity Director	2,935	3,223	34,458	10.69	9
10	Activity Assistants	6,589	6,880	50,288	7.31	10
11	Social Service Workers	9,412	10,481	136,513	13.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,890	22,639	204,334	9.03	15
16	Dishwashers					16
17	Maintenance Workers	3,449	3,721	47,074	12.65	17
18	Housekeepers	23,529	26,036	229,094	8.80	18
19	Laundry	10,112	10,807	85,617	7.92	19
20	Administrator	1,772	2,056	85,800	41.73	20
21	Assistant Administrator	368	384	6,841	17.82	21
22	Other Administrative	2,080	2,080	113,567	54.60	22
23	Office Manager					23
24	Clerical	10,927	12,133	123,442	10.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,821	2,013	22,399	11.13	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,935	1,935	73,746	38.11	33
34	TOTAL (lines 1 - 33)	205,706	221,570	$ 2,858,055 *	$ 12.90	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	237	$ 10,065	01-03	35
36	Medical Director	monthly	9,000	09-03	36
37	Medical Records Consultant	monthly	4,128	10-03	37
38	Nurse Consultant	24	2,040	10-03	38
39	Pharmacist Consultant	monthly	4,620	10-03	39
40	Physical Therapy Consultant	55	3,242	10a-03	40
41	Occupational Therapy Consultant	29	1,916	10a-03	41
42	Respiratory Therapy Consultant	2	72	10a-03	42
43	Speech Therapy Consultant	11	574	10a-03	43
44	Activity Consultant	41	2,119	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	399	$ 37,776		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 324	10-03	50
51	Licensed Practical Nurses	4,447	146,315	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	4,455	$ 146,639		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Miron Tabic	Administrator	0	$ 85,801
Linda Weiss	Asst. Admin.	0	6,841
Yosef Davis	Administrative	72.34	15,438
Yehoshua Davis	Operations	0	66,640
Moshe Davis	Operations	0	31,489
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 206,209

B. Administrative - Other

Description	Amount
Management Fees - InterCare Ltd	$ 72,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 72,000

C. Professional Services

Vendor/Payee	Type	Amount
Econocare	Purchasing Consultant	$ 2,538
Kipp Computer Solutions	Computer Services	9,510
Foley & Assoc.	Certificate of Need	6,000
DA Syntec Ltd	Strategic Analysis	2,130
FRS Healthcare	PMA Audit	3,000
Personnel Planners	Unemployment Consultant	2,285
S&K Medical Center	Quality Assurance	1,000
Various - See Attached	Legal	5,546
Frost Ruttenberg & Rothblatt	Accounting	36,165
American Data	Computer Services	4,902
Managcare	Bookkeeping	202,488
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 275,564

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,315
Unemployment Compensation Insurance	26,549
FICA Taxes	214,598
Employee Health Insurance	90,583
Employee Meals	16,272
Illinois Municipal Retirement Fund (IMRF)*	
City Payroll Tax	6,047
Other Employee Benefits	5,613
Christmas Expense	3,306
Employee Pension	9,450
Disability Insurance	2,977
TOTAL (agree to Schedule V, line 22, col.8)	$ 424,710

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,368
Health Care Worker Background Check	
(Indicate # of checks performed 97)	797
Licenses & Permits	4,509
Annual Fee	75
Advertising & Promotion	18,193
Dues & Subscriptions	5,303
Allocation from ManagCare	522
See Supplemental Schedule	60
Less: Public Relations Expense	( )
Non-allowable advertising	(18,193)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,634

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,823
Allocation from ManagCare	637
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,460

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Brightview Care Center # 0030551 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC $7,743

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 2,444 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 78,508
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 16,272 Has any meal income been offset against related costs? No Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.